Mental Hospitals

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Presentation of Achievement Awards: L. to R.: Dr. W. W. Bourke, VA Area Chief, Minnesota, Dr. Harvey J. Tompkins, Acting Medical Director, A.P.A., Dr. J. O. Cromwell, Blackfoot, Idaho, winner of the first award, and Dr. C. H. Skitch, Montreal, Que.

Sixth Mental Hospital Institute Issue

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THIS MONTH'S COVER

The Annual Achievement Awards, presented this year by Dr. Harvey J. Tompkins as Acting Medical Director and Program Director of the Sixth Mental Hospital Institute, are now in the form of engraved silver plaques mounted on walnut. In the picture, Dr. J. O. Cromwell, Superintendent of State Hospital South Blackfoot, accepts the first award; Dr. William W. Bourke (left) VA Area Chief, received an honorable mention certificate on behalf of Perry Point VA Hospital and Dr. C. H. Skitch received the certificate for Verdun Protestant Hospital, Montreal. Silver plaques also went to Modesto State Hospital, California, and Parsons State Training School, Kansas, second and third award winners.

Despite the largest attendance in the history of the Institutes—over 350 from 46 states and 9 Canadian provinces—audience participation was extremely high, an estimated 130 people speaking extemporaneously from the floor during the 14 sessions. Comments made during the meeting to staff members, consultants and program committee members showed that the feeling-tone of the meeting was such that everyone, whether or not he spoke publicly, felt integrally a part of the group. This was apparently just as true for "first-timers" as for old-timers. That the meeting was truly a hospital-wide affair was shown by the fact that 157 of the delegates were non-medical, e.g., representatives of other hospital disciplines.

Much of the credit for this success goes to the Discussion Leaders, both for their command of their subject matter and their ability to stimulate discussion. Where the pros and cons were aired, the sessions tended to be more interesting, stimulating and educative. Still greater audience participation, plus even greater frankness in stating views not perhaps shared by the discussion leaders will help to make future Institutes more stimulating.

The Consultants feel that they must also pay tribute to an exceptionally energetic and able Local Arrangements group, especially for the transportation and public address arrangements, and the entertainment after the banquet. Fine accommodation at the Hotel Nicollet, excellent food and cheerful, quick service greatly facilitated the mechanics of the meeting and made it more enjoyable.

The only unhappy note was the absence of the Medical Director, Dr. Daniel Blain, owing to illness. Consultants and Faculty Leaders sent a telegram of greeting to Dr. Blain the day the Institute opened.

The next meeting is to be held in Washington, D. C., and will as usual, be the third week in October. If arrangements can be made, Denver, Colorado, has been tentatively chosen for 1956.

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Trends in Mental Hospital Administration

Abstracted from the Address Given by the President of the American Psychiatric Association at the Sixth Mental Hospital Institute, Minneapolis, Minn.

ARTHUR P. NOYES M.D.

Without depreciating in any way the value of other psychiatric meetings, at many of which significant contributions are made to some aspect of scientific psychiatry, these Institute meetings are perhaps the ones at which the speaker feels especially at home. At the first of them Dr. Blain announced that their purpose was to be to provide for the exchange of views, ideas and experiences among persons interested in the mental hospital field. From the first he was wise in deciding that invitations should be extended to all interested professional and lay personnel. From their inception, therefore, attendance at the Institutes has included not only state and provincial hospital superintendents, Veterans Administration hospital managers, medical directors of private hospitals and commissioners of mental health but also hospital managerial personnel, nurses, social workers, psychologists, hospital trustees and others. As has been highly desirable, these other professions have made available their knowledge and experience. The policy that more time be devoted to free discussions than to formal presentations has also met with wholehearted approval.

In 1916, Dr. Henry W. Hurd wrote: "It is evident that a gradual evolution has occurred in the care of the insane in America during the past half century." The mere fact that so many persons having a definite and personal interest in the whole subject of mental illness are gathered here tonight is ample proof that this evolution has continued. As I look back, I am inclined to believe that this evolution has continued at an even accelerated pace.

I trust that I may be pardoned if I digress a moment to illustrate Hurd's forward-looking views. At the annual meeting of the Association in 1892 it was voted to change the name "The Association of Medical Superintendents of American Institutions for the Insane" to "The American Medico-Psychological Association." Hurd's discussion of this is illuminating. "In the past," he said, "the Association has been very largely composed of asylum superintendents, of men who were here simply because they were superintendents of asylums. This was extremely important during the constructive era of American asylums but the time has come when its members should not only be superintendents and managers of asylums but foremost in psychological work."

Although it is not true that during the past half century superintendents of public mental hospitals have, with a few notable exceptions, been "foremost in psychological work," yet the average of professional competency in the theory and practice of psychiatry among them has been the highest in the history of American psychiatry. This has been particularly true since the establishment of the American Board of Psychiatry and Neurology in 1934. One trend in mental hospital administration, therefore, has been a progressive advance in superintendents' knowledge of psychiatry as a branch of medical science.

Recent Trends

While great advances in mental hospital administration have been made in recent years it is but logical that these should have been less striking than those in the theory and practice of psychiatry. Many of the thirteen founders and their successors were able and progressive administrators. Mental hospital administration therefore, was a subject of careful study long before present concepts of a dynamic psychiatry were formulated or current techniques of therapy employed.

One of the significant trends in the past fifty years has been the shift from the mass to the individual. Formerly the emphasis in hospital administration was to a large extent directed toward the common welfare of the group—e.g. that patients be assured of adequate and suitable food, that they receive necessary nursing care and attention, that overcrowding not be unduly great, that there be no lack of clothing or other physical necessities. Today it is assumed that the physical needs of the group are reasonably met and that more attention should be paid to emotional and therapeutic needs. I think it has been increasingly recognized by the public hospital superintendent that every administrative act, every system set up, every method used in carrying out the purpose of the institution has a potential or actual effect upon the mental state of the patient.

In spite of the increased emphasis on therapy, public psychiatric hospitals still reflect too many of the traditional views, attitudes and parsimony which have so long prevailed. One of their chief defects is their usually inordinate size, determined presumably by expediency rather than by a well-considered policy. The individual patient in the large hospital cannot receive the same degree of consideration of his specific needs as is possible in the small hospital. The care of patients tends to become mechanical. Policies fit the size of the institution rather than the needs of the patient.

There is one change of the greatest significance. Formerly it was a frequent practice to locate mental hospitals in a rural area remote from a large city or medical center so that public transportation facilities are either lacking or inadequate. The institution is usually hopelessly handicapped in securing staff of all kinds. The New York Department of Mental Hygiene has recognized the desirability of locating a mental hospital near a medical educational center by placing its forty-five million dollar state hospital in the Bronx.

Within my professional experience the practices and problems in the public mental hospital have probably changed more than they did in the

previous seventy-five years. No longer, for instance, is it considered necessary or desirable that any large number of the hospital employees live in the institution. It is preferable that an employee be drawn from the permanent residents of the community where he may enjoy the same status as his neighbor and need have no contact with the hospital except during his hours of duty.

Medical Staff Development

The greatest change with respect to personnel, however, is the medical staff. Formerly the younger members of the staff were recent graduates who sought appointment either directly after graduation or upon completion of interneship, not because of a fundamental interest in psychiatry but because a salaried position met the need for an immediate income. It was usually required that the young doctor live at the institution where neither his professional nor social status was as highly regarded as that enjoyed by his fellow physician who had entered private practice. If he married, his wife must live in a constricted environment and his children be raised under socially artificial conditions.

Today no young physician enters psychiatry unless he expects to devote his professional career to this specialty. He will accept no position that does not afford opportunity to acquire the supervised training required by the American Board of Psychiatry and Neurology. No state, therefore, can expect to have a qualified psychiatric staff hereafter unless it provides such opportunity for satisfactory training. If such training facilities are available a hospital will have no serious difficulty in securing younger assistant physicians. Since, however, very few psychiatrists plan to follow public mental hospital work after they have passed the Board examinations, there is a dearth of material for senior and more responsible positions. It is, therefore, highly important that the states give thought to means whereby a state hospital career may be made more attractive. Medical staff members should be given more opportunity for personal growth, more responsibility, more opportunity for study and more recognition for their work. Many hospitals have promoted, not combatted, a social and intellectual isolation. It is perhaps not too much to expect that certification by the A.P.A. Committee on Certification of Mental Hospital Administrators will mean as much for mental hospital administration as has certification by the American Board of Psychiatry & Neurology meant for clinical psychiatry. Certification by both these Boards can be secured only by the administrator of superior qualifications and should be evidence of his fitness for great public service.

A highly desirable change in hospital-community relationship during recent years is the increasing interest which many communities take in the local mental hospital. It is, of course, highly important that the hospital have the confidence and respect of its local community. When this exists, the admission of the mentally sick person will usually be sought relatively early. In its absence, his admission will be deferred as long as possible, perhaps with a loss of curability. It follows that persons who have been responsible for the criticism, attack and abuse of mental hospitals in the public press have been guilty of a great disservice to the mentally sick by indirectly depriving them of the prompt treatment which might have led to their recovery.

Hospital-Community Relations

I have long felt that state hospitals neglect one important means of improving their relationship with the medical profession and, through it, their relations with the community. The family physician who sends a patient to a state hospital probably receives no information from the hospital concerning that patient and may not even know of her discharge unless he accidentally meets her on the street. If he had been advised from time to time about her treatment and progress, and on her discharge had received a letter to that effect together with any recommendations for further treatment, he would be highly appreciative of such a professional courtesy. The result of the effort would be greatly rewarding.

The establishment of a community mental health program through clinics and other means of mental health service is, of course, one of the most desirable means of making a hospital understood by the community.

In this country it has always been assumed that the responsibility for the care and long continued treat-

Exhibits at Institute

This display, showing which patients were working or available for work in 52 hospital areas, was made by Industrial Therapy patients at St. Peter State Hospital, Minnesota. The National Association for Mental Health showed an exhibit illustrating their many activities and Veterans Administration had an exhibit on lobotomy techniques.

ment of the mentally ill rests on the respective states, yet there has been no uniform administrative organization for meeting this obligation. Today, however, the administrative responsibility for the numerous state problems which arise directly or indirectly as a result of mental illness constitute such a large and technical function of state government that there is an increasing tendency to place all such services in charge of a single administrator, appointed by and responsible to the governor, with authority commensurate with the responsibility. Most observers believe this slowly increasing tendency is desirable, and that there is improvement in the performance of the state's functions relating to mental health activities when these functions have departmental status and are directed by a psychiatrically qualified commissioner removable only for proven cause of a nonpolitical and non-personal nature.

That active therapy for the acutely ill psychiatric patient can be carried out in the setting of the general hospital is one of the great steps forward in the practice of medicine. It not only integrates psychiatry and other branches of medicine but leads to a much more ready acceptance of treatment by the patient and his family. The educational value to the internist and the surgeon is too well known to require comment.

Other Disciplines

A trend which should be further encouraged is the establishment of a medical and surgical department in the state hospital. The psychiatrist soon loses interest in other medical specialities, and problems of medicine and surgery become of secondary interest. It is probably desirable that this department, housed in its own building, should contain only beds for cases requiring diagnostic observation and study or active treatment rather than ones for the chronically infirm. A member of the psychiatric service should make a daily liaison visit. In one hospital the annual death rate for all patients under treatment during the year has been reduced from 7 percent to 4.65 percent since a special medical and surgical department was established.

It is desirable that a full-time graduate social worker be assigned to the medical and surgical department; and the increasing practice of having a graduate social worker assigned full time to the admission service has much to recommend it.

Many institutions have within recent years created the position of personnel officer. It has usually been found that this officer has been of great assistance in the recruitment, selection and orientation of new employees, the handling of grievances and the maintenance of good morale.

The movement towards making protection unobtrusive is a step toward making life in the mental hospital approach more nearly the normal community life and has a wholesome therapeutic effect. The practice of admitting "day" patients with relatively mild illness is feasible in the psychiatric service of a general hospital or in a receiving hospital; yet this procedure has not yet been given as extensive a trial in state hospitals as it deserves.

Although we certainly feel discouraged and frustrated, the progress in therapy has been one of the great achievements of psychiatry during the past thirty years. I refer not merely to the somatic and neuro-surgical therapies but also to psychotherapy. I believe that one of the most deplorable circumstances in public mental hospital practice is the fact that the size of the staff does not permit more psychotherapy with the acutely psychotic. It is in the state hospital that group psychotherapy probably has its greatest even though limited usefulness. Nor should one fail to mention the great group of auxiliary therapies and their constantly increasing and constructive use.

Although there is still much to be learned concerning the causes, prevention and treatment of mental ill health, yet it is a great satisfaction to the mental hospital administrator to note that the therapeutic efforts of the institution seem in many instances to have been helpful to the patient in the establishment of a healthier pattern of living. The administrator eagerly awaits for the research therapist to give him more delicate and more effective tools in order that through them, more patients, no longer troubled in mind, may return to a happy and useful place in the community.

Contribution of Private Hospitals to Training and Research

Disc'n Leader: Dr John M. Donnelly, Hartford, Conn.

"Private hospitals are looked upon as a sort of pilot plant in training and research," said one private hospital director. They have, on the whole, greater independence in planning their research programs and expenditures than do state institutions, but less money to spend for this purpose. Very few private hospitals can undertake the broad-scale clinical research which public hospitals conduct. They lack the clinical material— i.e., large numbers of patients, particularly long-term cases—necessary for *statistically* validated studies. Thus a different sort of clinical research is the rule, one based on the more intimate doctor-patient relationship achieved in a private hospital setting, and founded less on specific protocol than on empirical techniques.

Informal "observational research" can make its contribution to the more structured research efforts of others by checking on reported results. Dr. Donnelly noted that when any new drug or technique comes out, "optimism is the rule of the day," and felt that private hospitals can help verify their worth.

Several of the doctors agreed that the private hospital's place in research was primarily in corroborative work. It was noted, however, that original research is going on in some private psychiatric institutions.

The group debated about how much the patient should pay for the cost of research and training, whether they were sufficiently stimulating to the treatment program to justify their being added to the cost of hospitalization. The answer was said to lie, instead, in separate financing by training and research foundations such as a number of private hospitals have established.

(Among those who contributed to the above discussion were Sister Marie LeGras, Drs. Josef A. Kindwall, J. Butler Tompkins, Francis W. Kelly, and Robert Gibson, Mr. W. M. Swenson and Mr. Joseph Greco.)

THE COST OF PSYCHIATRIC CARE

Discussion Leader: Sidney Spector.

Is it possible to evaluate how good is the care being given to a public mental hospital patient simply by quoting the per diem cost of maintenance, and comparing one state with another, was one of the questions raised during this discussion. Most speakers thought the comparisons themselves were invidious, disregarding as they do variations in standards of living, salaries and other geographic variables. Moreover, it was pointed out, approval by the Joint Commission on Accreditation of Hospitals would automatically be given to the hospitals with the highest per diem rate, if financial standing were the determining factor. One speaker spoke of "political per diems", pointing out that however high the country-wide standard of financial support, one state certainly had to be the 48th. Moreover, claimed another, the very fact that a neighboring state had a much lower per diem rate than his own made it difficult for him to persuade his legislature that he needed higher appropriations for the operation of his own state hospital system.

A speaker from Tennessee, with the lowest per diem rate in the country ($1.18), said his ward employees were being exploited because of their genuine love of humanity. They worked a 72-hour week. He thought his hospital managed to give good and devoted care despite the fact that every penny had to count. The new Governor has appointed a psychiatrist-commissioner and Tennessee hopes to better the lot of its public mental hospital patients.

In Kansas, it was stated, there was a problem of a different nature, and this came back to the question of how one could relate realistically the amount of money spent to the discharge or remission rates in mental illness. Certainly Kansas could show great progress—475 graduates, for instance, from 11 different psychiatric training programs, a gratifying number of whom remain in the hospital system. The state has been able to achieve A.P.A. staffing standards, except for registered nurses, and these standards too would be met within the next two years. But what kind of figures would have to be produced in several years' time to justify these expenditures to the legislatures? It was necessary for the states to get together to get some authentic figures in terms of patient rehabilitation as related to the amount of money spent.

It was suggested that the most realistic approach to legislatures in asking for greater appropriations was not to quote comparative costs, but to point to the professional standards of the A.P.A. "Let us give good medical service," pleaded one speaker, "without kidding people that we are going to save them money immediately. Everybody knows that medical care costs money—the A.M.A. has faced the facts by interpreting to the public just how a general hospital spends $15, $16, or $17 a day, and yet keeps down the cost of medical care in relation to a decade ago." The public must pay whatever it takes to get a good medical program of any kind.

Costs of training and research were as vague and unsatisfactory as were the costs of care and maintenance. A suggestion was made that a centrally located research register might be of assistance in determining these costs.

The Council of State Governments is planning two major undertakings which will help in this field: a) a financial analysis of research costs and b) a list of research projects to be compiled on a national basis, in cooperation with the National Institute of Mental Health and other groups.

(Among those who contributed to the above discussion were Drs. Mesrop A. Tarumianz, B. F. Peterson, Alfred Paul Bay, Mr. Mike Gorman, Dr. Joseph E. Barrett, Mrs. Anna Scruggs, Mr. Carl E. Applegate, Dr. Theodore Dehn, Dr. Hayden Donahue, Mr. Robert E. Klein, and Dr. Harold Magee.)

USE OF VOLUNTEERS IN MENTAL HOSPITALS

Discussion Leader: Mrs. Miriam Karlins, State Volunteer Coordinator, Minnesota Dept. Public Welfare

"You can't *buy* that kind of service" said one hospital superintendent of his volunteer program. The volunteer's contribution to the patient's life was agreed to be a unique and valuable "something extra"—"They bring their life into ours and take our patients out into their life," another superintendent expressed it. The volunteer was also recognized as offering an invaluable service in public education. Just as word-of-mouth is recognized as the most effective advertising medium in commerce, so the volunteer's voice in the community is the hospital's most potent public education medium.

The value of the volunteer, the *good* volunteer, was not questioned. What makes a good volunteer was not, however, fully agreed upon. While most hospitals, particularly large state institutions, are justified in maintaining rather rigid criteria, one doctor made a plea for "liberalism" in screening and orientation of volunteers. His hospital, he said, was only too happy to accept those persons rejected by other institutions as "pathological do-gooders." Their orientation and training came not in lectures and forewarnings, but in working with the patients in the best manner they knew. Another doctor pointed out that this was a rather exceptional case, however. This particular hospital has for many years enjoyed a high reputation in its community, both for its orientation and clinical practices. His own institution had not been so fortunate and he felt it essential that citizens who volunteered to serve the hospital be properly instructed in its aims and handicaps, and be shown how they can best help.

Attention was given to volunteer efforts other than those involving direct work with patients, and to the recognition which volunteers should receive.

Discussion of the lines of authority under which volunteers should operate brought out the oft-expressed and too rarely fulfilled need of having a full-time coordinator of volunteers at both the hospital and the state level. In any event, one participant declared, any superintendent who wants to make his institution better can find a way to get a volunteer program going. The superintendent's genuine interest and support, and staff acceptance of the program, were deemed essential to success. In one state hospital where the volunteers are organized as an autonomous group, their president has direct access to the superintendent.

(Among those who contributed to the above discussion were Drs. Granville Jones, Robert Hyde, O. A. Kilpatrick, H. S. Magee, and Robert Garber, and Miss Mary Mackin of the American Red Cross.)

Anna State Hospital, Illinois

The volunteer brings in a unique contribution—she brings neighborly companionship from the outside world. This elderly patient enjoys talking with somebody even though she may not feel well enough to take part in any activity.

CRITIQUE OF SOMATIC THERAPIES

Excerpts from the Academic Lecture given at the Sixth Mental Hospital Institute by DR. LAUREN H. SMITH*, Physician-in-chief, Institute of the Pennsylvania Hospital, Philadelphia.

Copies of the full presentation available from M.H.S. on request.

Considered in our critique are only those treatments with which most of us are presently actively concerned, pharmacological and general therapy, electroshock, insulin therapy and psychosurgery.

Pharmacological and General Therapy

There are many ancillary somatic treatments employed so commonly that their real value in the management and comfort of patients is often taken for granted. This group of therapies is seldom definitive, but is adjunctive in the majority of hospitalized patients.

Perhaps the most important, and certainly the most commonly employed members of this ancillary group are the sedatives. We feel that the most useful sedative in a psychiatric hospital is sodium amytal, which is now prepared commercially for every type of administration. This drug offers: Quick action; strength of sedation; a relatively large margin of safety; little cumulative effect because of rapid elimination, and it produces very little confusion. These requirements are not as well met by any other member of the barbiturate group.

For mild, continuous daytime sedation, phenobarbital by mouth is perhaps the drug of choice. There are relatively few important contraindications to the use of sodium amytal or phenobarbital. Patients who are habituated to alcohol or the barbiturates usually do not respond well, and drugs belonging to other pharmacological groups should be used. We have found paraldehyde and chloral hydrate the most useful in such cases.

Where there pre-exists any tendency to mental confusion, such as in the organic syndrome of the aged, we have found it wise to be extremely cautious in the prolonged use of phenobarbital. Many of these patients are disturbed *because* they are confused, and any drug or procedure that might increase confusion will increase their agitation.

There are two special uses of sodium amytal which should be mentioned. The first of these is prolonged narcosis therapy, which had its greatest use in the middle '30's and is still occasionally used. This procedure is difficult, dangerous, expensive, and requires a large staff. Patients undergoing narcosis must have individual professional attention twenty-four hours a day for the week or ten days the treatment is in process, they must be in excellent physical condition, and the incidence of serious complications, such as aspiration pneumonia, is relatively high. Its principal use is in the hyperkinetic, acute syndromes, such as severe mania, severe agitated depressions, and acute catatonic states. These conditions usually respond quite readily to electroshock, where the risk to the patient and the expense to the hospital are much less.

The second special use of sodium amytal is the amytal interview, which proved a very useful therapeutic tool during World War II. Its chief therapeutic effect is based on the abreaction produced in acute traumatic neuroses and psychoses as soon as possible after their onset. The longer the delay between the precipitating trauma and the abreaction, the less useful the latter becomes. We have found the amytal interview of relatively little therapeutic value in civilian psychiatry.

Perhaps at the other end of the therapeutic scale from the sedatives are the stimulants, typified by the benzedrine group and thyroid. Our experience has been that this group of drugs is not of particular value as euphoriants in psychotically depressed or underactive patients. Their use with outpatients exhibiting a milder degree of depression or retardation is at times worth while, however.

Nicotinic acid in large doses, either alone or in combination with metrazol, is employed with patients showing impairment of cerebral circulation. Depressed or agitated seniles or arteriosclerotics are sometimes benefited by this treatment, when electroshock is contraindicated. The effect of nicotinic acid therapy in such patients is not extreme, but is often definite.

Some New Drugs

Tolserol (myanecin) has been used for symptomatic control or relief in patients exhibiting gross anxiety with tremors, such as severe anxiety neurosis, alcoholics and drug addicts during the withdrawal period, and in organic syndromes accompanied by muscular twitchings, such as Parkinsonism and arteriosclerosis. It has a definite though minor place in such conditions, but must be given in large amounts (1 Gm. qid) in order to have much effect.

Chlorpromazine (Thorazine) has not been in widespread use long enough to give a final estimate as to its value. It seems to have a moderate tranquilizing effect in overactive syndromes, such as agitated depressions and manias. Results with retarded depressions and underactive schizophrenias have not been noticeable. The drug may be given orally or parenterally, and usually has to be

* *Included as co-authors: Drs. J. Martin Myers, Jr., Harold H. Morris, Jr., Arthur L. Peterson, Franklin H. West, Per-Olof Therman, staff members of The Institute.*

administered for several weeks before there is any noticeable effect. It produces physical side reactions in a number of cases, so that it must be administered under fairly close medical supervision, particularly in the initial phase. It seems likely that thorazine may find a permanent place, particularly in those cases where other types of sedation or electroshock are contraindicated. For example, we have found it of benefit in severe cardiacs who are agitated or manic, where electroshock could not be used. It would not appear that this drug will replace electroshock to any great extent.

Serpasil (rauwolfia serpentina) seems to have less effect than thorazine on the patients' psyche; its effect is slower in appearing but is more sustained. We are not sure that either of these has successfully aborted an attack; they can best be used in syndromes whose natural history indicates a spontaneous remission, such as periodic attacks of excitement or agitation. They contribute to the comfort of the patients, make them easier to handle from the hospital's point of view, and potentiate other sedatives.

An Older Drug Re-Discovered

Carbon dioxide, as a physiologic agent, was dropped from consideration in 1928 as being of no value, only to be "rediscovered" and evaluated by Meduna some 18 years later. The gas mixed with oxygen (usually 30% CO_2 and 70% O_2) is inhaled by the patient as in anesthesia. He is then allowed to recover spontaneously. A minimum of 20 to 25 such treatments of 1 to 5 minutes is considered minimum for a fair trial of therapy.

It has been found to be of some use in treating anxiety states, some psychosomatic and tension syndromes, and stuttering. Not enough statistics are available to establish clearly its essential values. There are sufficient favorable reports to justify its continued use and investigation. Early reports indicate 60 to 70% improvement of selected cases, but more recent figures are more variable, and range from 30 to 60% improvement.

Inasmuch as everyone has had broad experience with hydrotherapy it need not be extensively discussed. It is felt, however, that some attention should be recalled to its importance because of the recent tendency in hospital construction and in the organization of patients' therapy programs to ignore this type of treatment.

Electrostimulation

By far the most dramatic of somatic therapies, electroshock has had widespread use, bringing symptomatic relief to hundreds of thousands since its introduction by Cerletti and Bini in 1938. It is the most significant treatment technique developed in the past 50 years especially in terms of its economic and social benefit.

Originally developed for application to schizophrenia, electroconvulsive therapy is now the treatment of choice in cases of involutional psychotic depressive reactions. Although slightly less effective, it is also applicable to other clinical syndromes manifesting depression or equivalent symptoms. Included here are manic depressive depressions, schizo-affective depressions, and neurotic (reactive) depressions. While of value in treating acute schizophrenia and the catatonic state, it is much less effective when applied to the simple and paranoid types. It is quick and beneficial in quieting the overactive and agitated patient.

Care in handling the patient, plus the use of curare, its derivatives, and synthetic curare-like compounds, have rendered treatment orthopedically quite safe. Long bone fractures are rare while the incidence of compression fractures of the spine ($\pm 2\%$) are at an irreducible minimum and seem to occur regardless of efforts to avoid them. Flexible restraint of the patient, rather than any particular position, seems to produce the least musculoskeletal morbidity. The convulsion modifiers—not without dangers in themselves—should be used only when indicated. Indications include active tuberculosis, thyrotoxicosis, and cases of recent coronary thrombosis, cerebrovascular accident or fracture. Sodium pentothal is often used to allay anxiety prior to treatment and it is claimed to soften the convulsion; it has no effect on the clinical result.

With practically no contraindications (except for severe general physical depletion and severe organ pathology in which any somatic insult might prove deleterious), and an ever widening area of applicability, electrostimulation has a remarkable therapeutic potential. It has the additional advantages of being inexpensive, conservative of numbers and time of personnel, and in selected cases it is a suitable out-patient treatment measure.

It is generally held that electrostimulation has a beneficial short term therapeutic effect. Evaluations of long term effect tend to show little difference between treated and untreated cases. Psychotherapy and environmental manipulation (both concurrent and subsequent to EST) would be the logical way of lengthening the duration of remissions.

Insulin Therapy

Insulin Coma therapy has been used in the treatment of schizophrenia for nearly twenty years. The general consensus of opinion is that it is an effective agent in altering the immediate outlook in this disease.

In view of the fact that this therapy has failed to increase the number of relapse-free recoveries, we conclude that its main effectiveness lies in improving the immediate prognosis.

Combined insulin coma and electroconvulsive therapy has been widely used, and with good results. The usual procedure is to give electroconvulsive therapy in addition to insulin to those patients who do not show good response to insulin, especially during the early part of insulin therapy. The apparent effect of electroconvulsive therapy on patients so selected is to increase the number of favorable responses to treatment to the level of the group which made good progress on insulin alone.

Is insulin coma therapy so much better than the other somatic therapies for schizophrenia that its higher cost can be justified? Few good comparative studies have been made. Gottlieb and Huston compared three groups of schizophrenics who received insulin coma therapy, electroconvulsive therapy, and psychotherapy respectively. They found no significant difference between the results of these therapies. Our clinical impression, as yet unsupported by a similar statistical study, is that insulin coma therapy does produce a slightly better and

S.K.F.'s Selective Neurologic Depressant

In Severe Excitement

THORAZINE*

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(Lehmann, H.E., and Hanrahan, G.E.: A.M.A. Arch. Neurol. & Psychiat. 71:227 [Feb.] 1954)

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longer lasting remission than does electroconvulsive therapy.

Subcoma insulin therapy has a definite sedative, weight-increasing therapeutic effect. Although it is useful in the hospital management of the undernourished, chronically anxious patient, the need for close nursing supervision during the hypoglycemic period makes this therapy more cumbersome than the usual treatment of such patients by sedation and psychotherapy.

In summary, the insulin therapies have been found effective in producing remissions in the schizophrenias and in chronic anxiety states. These treatments lack the capacity to alter the internal dynamic factors that predispose these patients to recurrences of their illness. In view of this fact the importance of continuous use of post insulin therapies and psychiatric management in the family setting is obvious.

Psychosurgery

It is apparent that after more than eighteen years of at times highly charged debate among psychiatrists, neurologists, and neurosurgeons, "psychosurgical" procedures are well established in the therapeutic armamentarium used against psychiatric illnesses. After probably more than 30,000 operations in this country alone, interrupting nerve pathways of the brain has not become the panacea as championed by some, nor has it produced a grotesque horde of amoral automatons as feared by others. The frequency with which this type of treatment has been used apparently reached a peak in 1949, declining slightly therafter.

It is more useful to think of this treatment in terms of decreasing severe crippling fears than as treating a diagnostic category or as a cure for the emotional illness. We have learned to recommend frontal lobe surgery in those cases who have failed to respond to other adequate courses of therapy, including the somatic such as electroconvulsive therapy, and who have been chronically crippled by anxiety, tension, fear or self-concern with or without other symptoms. The most spectacular results then (not surprisingly) are found in the incapacitated obsessive-compulsive neurotic who post-operatively usually retains his obsessional thoughts, but is no longer concerned with them. Similarly, the severe hypochondriasis of some patients is also relieved.

However, lobotomy has been done most frequently with the hospitalized psychotic and not nearly as much for the neurotic because it is a procedure with attendant operative risk, complications, and personality damage. There is a dulling of social perceptiveness and reactivity, some emotional blunting, loss of initiative and creativeness. These we do not risk without some concern in the neurotic so that the chronic schizophrenic is the largest diagnostic category treated. The excited, assaultive, disturbed patient has a much better chance of a good response than the apathetic or deteriorated one; the catatonic excitements and paranoid reactions do better than the hebephrenics. The agitated involutional psychotic reaction who has not responded to electroconvulsive therapy, is a candidate for a lobotomy if his hospitalization becomes prolonged; and he is more apt to gain a beneficial result than the retarded depression seen in manic-depressive reactions. All these respond better than the manics who do not respond well. We have not found ourselves inclined to recommend its use for the psychopaths, alcoholics or drug addicts.

We have made the above statements with some degree of assurance for they are based on the clinical observations of many of our colleagues who have reported on literally thousands of cases. Most reports reviewed classify results as "much improved" or "good" in about one-third of the patients, but in some reports "much improved" may mean nothing more than living a sheltered existence out of a hospital. To say just how beneficial psychosurgery is we find not easy. Even some improvement is important when one considers the number of patients who might be released from a hospital and who can gain some relief from their psychic tension.

When we read the claims and counterclaims made by the many modifiers of the prefrontal lobotomy concerning their particular modification we are left with the conclusion that the differences are more one of degree than of kind. We now have open and closed, bilateral and bimedial prefrontal lobotomy, transorbital lobotomy, lobectomy, topectomy, thalamotomy, cortical undercutting, ventromedial coagulation, anterior cingulectomy, as well as procaine injections and even transient or permanent frontal lesions by ultrasound. In spite of the many contrasts in these methods which crowd the field of psychosurgery, the results are amazingly uniform.

There appears to be a better correlation of the results with the amount of destruction than with site of the destruction. Since its introduction into this country in 1946, transorbital lobotomy has grown greatly in usage despite criticism from neurosurgeons. From many of the published reports it appears that the operative fatality rate is less than for the open prefrontal operation. It is of interest that two investigators comparing results for two different sets of modifications concluded the less extensive was better except for treating hebephrenic patients. We are referring to Greenblatt comparing bimedial and bilateral procedures and to Freeman's comparing transorbital and prefrontal procedure.

To get the most out of psychosurgical procedures as with the other somatic treatments, we must consider many other aspects of treatment than the operation itself. We know that an improved chronic schizophrenic patient, ready to leave the hospital without a home prepared to receive him, is not likely to stay out of the hospital long. Intensive psychotherapy is possible with the patient, but must be modified; indeed we are inclined to agree with Denis Hill who states: "Psychotherapy, certainly of the analytic and probably of the cathartic variety will be for (the lobotomized patient) impossible. But educative and occupational psychotherapy persuasion and the re-establishment of normal and socially desirable methods of obtaining gratification of needs are necessary. . . ." We also need all of our resources, all the aids, somatic treatment, psychotherapy and the help of our ancillary services.

Research In Psychiatry

With respect to psychiatric research

dealing with problems in somatic treatments we have to admit that very little progress has been made towards a clarification of essential factors involved. As a matter of fact, the somatic treatments have remained empirical in nature. We seem to agree in our goals and, in general, to the treatment methods employed at present, but it would be an overstatement to say that our choice of treatment is based on scientific facts. Nevertheless, it is true that statistical evaluations of the effectiveness of these treatments have been helpful in our selection of certain treatments for specific forms of mental illness. The need of a solid foundation that rests on scientific criteria is well recognized and can be alleviated only by research projects adhering strictly to present concepts in psychiatry and correlating them with basic sciences. There is too much speculation and a tendency to play on hunches without an appreciation of psychophysiological principles.

It is important to note that although somatic treatments initiate primary physiological responses with subsequent psychological reactions, the attention has been exclusively concentrated on the psychological aspects. It seems that a better understanding of somatic reactions essential to beneficial psychological reactions would be a fruitful research problem emphasizing psychophysiological unity. There is ample evidence that no single somatic factor can be regarded as essential to psychological improvement, thus, we have to look more for common factors in treatment and their relative importance to different forms of mental illness.

The question of how specific a given somatic treatment is with respect to diagnostic groups is another problem closely related to the more general question of essential factors in somatic treatments. Much depends on how we evaluate improvements as such and how closely our evaluation adheres to basic concepts in modern psychiatry. At the present time there are no uniformly accepted criteria for improvement and what is even more disturbing, the different criteria used have little to do with such basic concepts as repression, anxiety and defense mechanisms and even less with physiological factors.

To recapitulate, we may say today that a few pharmacological preparations, especially chlorpromazine and serpasil are consistently altering mental and emotional conditions, primarily tension states, manic or agitated reactions; that electrostimulation with many new refinements in technique, is more helpful specifically in depressive states, with fewer troublesome side effects; that insulin therapy retards the illness or shortens hospitalization, thereby aiding and abetting therapeutic endeavors in psychotherapy, and that psychosurgery has levelled off from its over-enthusiastic beginning, and in conservative hands may contribute a great degree of mental health, peace and relaxation to our most troubled clinical syndromes, when thoughtfully selected.

Difficulties in terminology, in measuring accurately, in standards applied make our evaluation crude. But we do know that patients don't stay in hospitals as long—they don't stay ill as long.

Regional differences and staffing problems in various sized hospitals make one or another treatment procedure practical or impossible. Each of us must determine what treatment shall be best applied in each situation.

Today in psychiatry I like what I see happening—I am confident and assured that it is good. Soon I hope to comprehend it better—and I know now more than ever before that psychiatry is a field of positive therapy.

GOOD PRACTICES KEEP GOOD PEOPLE

Disc'n Leader: John M. Hendricks, Memphis, Tenn.

A good personnel program, it was stated, is one which coordinates the employees' needs with those of the institution. The hospital which has good physical working conditions and, even more important, stable personnel policies is one whose operation is in the least danger of disruption by constant turnover of personnel.

Prestige is a very real factor in job satisfaction. Too often the physician in state hospital work has a lower professional and economic standing than his colleagues in private practice. One large state hospital has had some success in correcting this difficulty by arranging teaching and research affiliations with a leading medical center in its area. Research grants have been obtained from several large pharmaceutical firms, which provide extra compensation since the work is done on the researchers' own time. The hospital also encourages its doctors to engage in limited private practice away from the hospital.

Promotion within the ranks was mentioned as an excellent personnel practice; it shows employees that their good work is appreciated and rewarded. Training programs were also said to be profitable in terms of providing job satisfaction; both the teacher and the trainee gain added stature.

Clear communication is essential. One administrator urged his colleagues thus: "When you send out a directive, say what you mean and mean what you say."

The practice of giving maintenance as a part of salary was deplored: "Don't try to tell your personnel how to live." This participant, who has spent many years as a state hospital superintendent, urged instead that the employees be given "cash and freedom." He felt that maintenance should be optional and offered at prices more consistent with what the services would cost in the community: "Offering your employee a 30-cent meal doesn't fool him into thinking you're giving him a raise in salary."

Recreation for employees can be a part of "good working conditions." In line with this, one hospital urges all its employees, particularly those below the administrative level, to take part in planning and personally participating in community services, such as mental health radio programs.

Certainly money should not be disregarded as a vital factor in job satisfaction. As a state mental health commissioner facetiously enquired: "What would make you quit your job sooner than anything else if it were taken away???"

(Among those who contributed to this discussion were Drs. F. J. O'Neill, W. F. Green, S. O. Johnson, Joseph Barrett, and Ralph M. Chambers.)

COMMUNITY PLANNING FOR MENTAL HEALTH

Discussion Leader: Dr. Robert C. Hunt, Albany, N. Y.

Taxpayers and legislators have been promised that more active therapy and more intensive research will reduce the number of hospitalized mental patients so that, within measurable time, if sufficient money is invested in research and active therapy, no additional capital construction will be needed, or that, at least, the need will be drastically reduced.

Most hospital psychiatrists, however, while believing wholeheartedly in the humanitarian and sociological value of the therapeutic dollar, do not agree that immediate substantial tax savings can be achieved in this way. Instead they agree with the statement made by the National Governor's Conference on Mental Health, when it declared in Detroit this spring: *"Ultimate* reduction of the population in state mental hospitals can only be achieved by efforts to prevent mental illness."

Such preventive measures, of course, must focus on the community. The development of community service depends upon the development of local interest among all the citizens; it depends also upon adequate personnel —we all know there is a woeful shortage of all types of professional workers; many more must be trained to carry out any plans we make for prevention of mental illness.

Clearer Concepts Needed

We psychiatrists must develop more clear cut concepts of the goals and methods for which we are striving, in trying to develop community mental health services. We must decide what direction our major efforts should take—early treatment for adults or children? inpatient or outpatient care? rehabilitation for the ex-hospital patient? education of professional people or of the general population? sociological approaches to conditions in our society which affect mental health? Obviously we must move in all these directions.

Then there are the various types of organizations for carrying out such a program—local mental health services, services provided by a central state agency, a public health department and so on. Most important, we must seriously consider the use of public health agencies, because these ubiquitous agencies have well developed techniques of community organization and education.

Two-Way Responsibility

Meanwhile, during the period when new professional personnel are being trained to take over these programs, more use should be made of the general practitioners in the community and of the psychiatrists who are in private practice. The general practitioner is undeniably the center of the general health program in any community. We must never allow our mental health program to be separated from the general health program or the general medical profession in the community. To do so is to court hostility and frustration of our efforts.

No mental health program can be successful unless effective treatment is provided for those already ill. The vast majority of such treatment takes place in the public mental hospital, thereby putting this institution in a strategic position to provide excellent community services. In fact, the tax-supported psychiatric hospital is unquestionably the backbone of any good community mental health program.

But if the public mental hospital is in a specially favorable position to be the nucleus of such a community mental health program, and has a special responsibility to the community for this reason, it is equally true that the community in return has a responsibility towards the hospital, over and above getting it adequate appropriations. This responsibility can be met in many ways—by active volunteer programs, to bring to the hospital, services which are over and above the absolute necessities of care and treatment; interested, intelligent boards of control or trustees, who as leading citizens in the community take the trouble to inform themselves and others as to whether indeed the patients are receiving the full benefit of the care, treatment and research monies appropriated, and if they are getting active consultative help from surgeons, internists and other medical men in the general health community.

Overall Plans Needed

At present, there is uneven distribution of such community facilities as outpatient, all-purpose clinics for adults and children, rehabilitation facilities for ex-hospital patients, well-baby clinics, counselling services, and short-term treatment units for inpatients in general hospitals to prevent long term hospitalization.

It will be necessary, therefore, for most areas to develop a carefully thought-out, overall plan, based to some extent upon plans now in existence in California and New York State, but tailored to suit local needs and existing local facilities.

(Among the participants in the above discussion were: Dr. Mesrop A. Tarumianz, Dr. Joseph E. Barrett, Dr. Crawford N. Baganz, Dr. O. A. Kilpatrick, Dr. Hayden Donahue, Dr. Paul Lemkau, Dr. James O. Cromwell, and Dr. James T. Shelton.)

STATE SURVEYS

Discussion Leader: Dr. Harvey J. Tompkins, Washington, D. C.

The history of the State Surveys being done in the Medical Director's office under the professional guidance of Dr. Daniel Blain began with the Louisiana report a year ago, when the Medical Director was approached by this state with a request for professional guidance. After some discussion it was determined that the Louisiana Report should be in the nature of a pilot study, to see in what way the Medical Director of the A.P.A. could be of maximum assistance to states desiring to improve their overall mental health programs.

The format was decided upon and set up by Dr. Blain, in consultation with the state authorities, and this format has been revised slightly but kept in essence in the subsequent reports which have been produced—the Indiana Survey Report, now nearing completion, and the Arkansas Survey Report, which will be completed in a few months. The Governor of Ohio is also engaged in making arrangements for a similar survey report to be done on his state.

First of all, the Surveys have to be requested by the state, and this request usually comes from the Governor. The Governor then appoints a local fact-finding committee, composed of leading citizens and others who are professionally interested in the mental health problem. This committee, which functions sometimes under the chairmanship of Dr. Blain himself and sometimes has a local co-chairman as well, is responsible for getting together all relevant material relating to present facilities, how well they operate, how adequate they are to meeting the existing needs, and so on. Public hearings are held in the course of the Survey, to enable all interested civic and professional groups to present their needs and recommendations. In Louisiana, when the public hearings were held, representatives from 32 different organizations came personally and 13 sent written testimony as to what they considered was needed for a good mental health program, expressing their own interests, hopes and plans and what they considered their roles to be. "This is a good healthy approach" declared the Medical Director at that time.

The Medical Director and professional associates, with all the facts in their hands, bring professional experience to bear upon the specific problems of the specific state, and endeavor to determine if the existing resources are being used effectually and in what areas more are needed. From these conclusions plans for the future are recommended. The report on the survey is written in the Central Office of the A.P.A. and given to the state to make what use they wish of it. If required, and in accordance with his official capacity in the A.P.A., the Medical Director will testify at the public hearings or before the state legislature on what, in his professional judgment, is required in the state.

It is a pre-requisite that a State requesting a Survey must have had or must simultaneously request inspection of its hospitals by the Central Inspection Board.

There has been some confusion between the nature of the State Survey Reports and the Central Inspection Board Hospital reports. The basic difference is, of course, that the C.I.B. reports are official documents, based upon existing standards, and leading, hopefully, to approval. The State Survey Reports are a collection and evaluation of material for easy reference, to enable interested citizens and officials within the state itself to work out a better overall plan for mental health. Moreover, the C.I.B. reports are confined to public mental hospitals and commissioners' offices, whereas the Survey reports include material upon outpatient clinics, teaching centers, and community facilities of all kinds.

The question was raised as to whether or not a professional organization such as the A.P.A. has the right to produce such Reports, in view of the fact that no such report, involving public hearings and testimony before legislatures and budget committees can be divorced from political implications. But who, it was asked, will do it, who is capable of doing it, except a professional organization? No other organization has the knowledge, the professional experience and the integrity to carry out such a survey and to make such recommendations.

The director of the National Institute of Mental Health has indicated that the facilities of his organization are available on a consultation basis.

Among those taking part in the above discussion were Dr. G. W. Davis, Jr., Mr. Robert H. Klein, Dr. Lowell O. Dillon, Dr. Paul Lemkau, Mr. M. Gorman, Dr. Hayden Donahue, Dr. Mesrop A. Tarumianz, and Dr. S. Wick.

Certification Committee Holds Second Examination

The A.P.A. Committee on Certification of Hospital Administrators held its second examination at the Hotel Nicollet, Minneapolis, on October 16th, immediately preceding the Sixth Mental Hospital Institute. Seventy-six candidates were certified by examination, which, added to the 142 who previously qualified, makes 218 successful candidates to date.

The Committee has recently made a new ruling of great importance to those who wish to apply for certification on their record (the so-called Class I applicants). *No such applications will be acted upon unless they are received by July 1st, 1958.* The Committee feels that people desiring to be certified on their record will have had ample time by this date to submit their applications. Thereafter all applicants will be required to take an examination.

Those who are eligible to be considered Class I applicants who may apply for certification on their record must be Fellows of the A.P.A., have graduated from medical school prior to June 30th, 1938, and be currently engaged in mental hospital administration as superintendents or assistant superintendents. Psychiatrists who are Fellows of the A.P.A. and not currently engaged in mental hospital administration but who have served in such capacity for three years previ-

ously are also eligible as Class I applicants.

The next examinations will take place on Saturday and Sunday, May 7th and 8th, 1955, at the Traymore Hotel, Atlantic City, immediately before the A.P.A. Annual Meeting. The closing date for receipt of applications for this examination is March 1st, 1955. Applicants will be examined orally in at least, but not limited to the following fields: the organization, staffing, management and control of professional services for medical care; techniques and application of community relations, including methods and media; the management and control of personnel administration, including recruitment, classification, on-the-job training, promotional and disciplinary policies; the legal aspects of mental hospital administration, including commitment procedures habeas corpus procedures, required legal certifications and other pertinent aspects of forensic psychiatry; the general principles of budget preparation and budget control; business and finance management, including requisitioning procedures, allotment procedures and policies; the organization of a mental hospital, including methods of managing, supervising and studying department functions and the medical audits of various departments and divisions of a hospital; procurement, warehousing, issue and control of supplies and equipment; management and administrative control of the physical plant, including maintenance, repair, alterations and operation of utilities and service units, and planning for new construction; the administration, staffing, organization and control of outpatient departments, including mental hygiene clinics; the administration, staffing pattern, management and control of rehabilitation, re-education and job placement services; the organization, staffing, management and control of food service activities and the organization, staffing, management and control of educational programs. The candidate shall also be required to outline methods of effectuating programs and policies.

Application forms and further information is available from the Secretary, C. N. Baganz, M.D., Veterans Administration Hospital, Lyons, N. J.

Care of Seniles In and Out of Mental Hospitals

Discussion leader: Randall R. MacLean, Division of Mental Health, Ponoka, Alta

Dr. MacLean, in presenting the subject for discussion, defined seniles as elderly persons showing signs of mental change of various sorts that make them unable to function in family and community life. He excluded persons showing only normal aging characteristics.

The number of seniles in new admissions to mental hospitals has increased greatly in recent years, and more patients in the hospitals are surviving to old age. Thus mental hospital administrators are faced with the problem of how to care for this large group of aged patients. It is estimated that 35 percent of the current mental hospital population is over 65 years of age.

Segregation in separate wards is not a solution. Staff members prefer to work with younger, more hopeful patients, and resent being assigned to the senile wards. Moreover, the physical set-up in most mental hospitals is not adapted to the needs and care of the aged.

Home care of seniles has become more difficult in recent years and fewer and fewer people are willing to provide it for their aged relatives. Paid help for the necessary 24-hour care is beyond the means of the average family, and medical care and medication is also too expensive. The present-day family and the present-day home are not geared to take care of senile relatives. Institutional care appears to be preferable.

Various opinions were expressed on the advantages of separate institutions versus mental hospital care. It was agreed that the mental hospital should care for psychotics, regardless of age, but that the non-psychotic elderly person does not belong there, and should not be placed there simply because he has no other place to go. If such persons are refused by the mental hospital, said one speaker, the community will have to provide alternative care. Experience indicates the great advantages of separate facilities for the normally aging. Both the mental hospital and the individual benefit. The removal of large numbers of aging people from mental hospitals improves staff morale; the care that can be provided elsewhere is more adapted to their needs; finally, the relatives generally feel that there is less stigma in such an arrangement than in mental hospital care.

Norristown (Pa.) State Hospital

Tending the rose bushes he planted outside the O.T. building gives pleasure to this elderly patient.

A plea was made, however, not to discourage admission of the aged to mental hospitals, but to accept them, rehabilitate them as speedily as possible, and discharge them, either to separate institutions or to their homes. It was said that relatives would cooperate in the return of elderly rehabilitated persons if they were properly approached.

Present practices are inimical to rehabilitation said another speaker. In some mental hospitals persons over 65 are not given the attention that younger patients receive. They have little chance for rehabilitation and usually deteriorate. Treatment instead of custodial care would show a high percentage of rehabilitation, and such elderly persons could be moved out of the mental hospitals to special institutions or to their homes. (Among those who contributed to the above discussion were Drs. J. O. Cromwell, G. Wilse Robinson Jr., George W. Jackson, M. A. Tarumianz and Ralph M. Chambers.)

Sources of Information and Assistance To Hospitals

Discussion Leader: Robert L. Robinson

Ten major agencies engaged in aiding mental hospitals through both professional and public channels, were represented at this session. Dr. Daniel J. Dailey, Asst. Chief of the **Division of Hospital Facilities, U.S.P.H.S.** described the aims and accomplishments of the Hospital Survey and Construction Program in meeting the great need for physical facilities. Canada's national mental health activities were outlined by Dr. Charles A. Roberts, Chief of the Mental Health Division of the **Department of National Health & Welfare,** which administers federal grants and advises the individual provinces in their programs.

Mr. Sidney Spector, Director of the **Interstate Clearing House of Mental Health** operated by the Council of State Governments, told about his agency's establishment to aid states in cooperative planning. The activities of the **National Association for Mental Health** were described by Mr. Paul Harris. These focus primarily on citizen efforts to improve mental health programs. Another citizens' group, the **National Mental Health Committee,** acts to influence legislation favorable to mental health programs. Mr. Mike Gorman, Executive Director of the Committee, told of its accomplishments in promoting understanding of the need for psychiatric research and training.

In June 1951, the **American Medical Association** was authorized by its House of Delegates to form a Committee on Mental Health. The Committee, whose work was described by its Secretary, Dr. Richard J. Plunkett, has formulated a thirteen-point program of activities which state and county medical societies could undertake. These points cover such areas as legislative recommendations, hospitalization insurance coverage, increasing of general hospital psychiatric services and community education.

Dr. Sarah H. Hardwicke, Assistant Secretary of the Council on Professional Practice of the **American Hospital Association,** mentioned some of A.H.A. services which benefit mental institutions. These services, her statement said, "are in the areas where the problems of mental hospitals are most closely allied to those of hospitals which care for other than predominately mental patients."

Mention was also made of the **Mental Health Materials Center,** which distributes literature and films for training and public education under the direction of Mr. Alex Sareyan.

A mimeographed summary of the activities, program, and services of the **National Institute of Mental Health, U.S.P.H.S.,** was also made available to all members of the Institute.

Mr. Robinson gave a brief account of the **American Psychiatric Association's** several offices which serve mental hospitals directly. Among these are, of course, the Mental Hospital Service, the Central Inspection Board, the Nursing Consultant's Office, the State Survey Office and the Hospital Architectural Study Project.

PLACE OF RELIGION IN MENTAL HOSPITALS

Discussion Leader: Chaplain Donald C. Beatty,
Veterans Administration Central Office

The value of a religious program in a mental hospital is no longer in question. All VA and many state mental hospitals have such a program as an integral part of the overall hospital program, and for the most part have full time chaplains of the three great faiths—Catholic, Protestant and Jewish. There are numerous associations giving psychiatric orientation to theological students as well as to full-fledged ministers who wish to know more about humanity's problems and especially the problems of the mentally ill and their families. Internships for theological students are offered at some mental hospitals with mutual benefit to student and hospital. It is a far cry from the dollar-a-year chaplain described by one VA doctor, who, 20 years ago, visited on request for the sole purpose of conducting religious services.

Today the chaplain's duties far exceed the mere conduct of religious services, essential as these may be. Individual counselling, visiting and interpreting the patients' needs to the relatives, sitting in at staff meetings, helping with local Alcoholics Anonymous chapters by conducting selected patients to their meetings—all these and many other duties fill the busy day of today's mental hospital chaplain.

Not so many years ago, it was recalled, there was considerable controversy as to whether psychiatry and religion could live side by side—or whether in fact, the one was not in direct opposition to the other. Today this controversy is no longer so evident—the chaplain and the psychiatrist understand that in fact they have a great deal in common. The psychiatric attitude of permissiveness no longer causes the chaplain to fear that that psychiatry is not only condoning but possibly even encouraging sin; one Jesuit, himself an analyst, declared that the permissive attitude of the psychiatrist in therapy was closely related to the attitude of the priest in a confessional—each was permitting and making possible the revelation of what was troubling the individual.

Today, however, when this semantic barrier has been crossed, perhaps the pendulum has swung in another direction. Now we find the young zealous clergyman who wishes to become a psychiatrist, junior grade. One such young man seriously proposed, said a participant, that clergymen take over all the psychotherapy in a hospital since the doctors were obviously too busy making physical examinations, giving electroshock and other such therapies! However, as one psychiatrist pointed out, these young zealots are growing fewer as the ministry in mental hospitals advances not only in age but in maturity. Once the clergyman understands that in attempting to act as a psychiatrist he destroys his own usefulness as religious counsellor, he will refrain from doing so; as a religious counsellor he is obliged to take a firm moral and religious stand—something not possible for the psychiatrist at all stages of therapy.

The discussion leader, himself a chaplain of 30 years experience and a pioneer in mental hospital chaplaincy programs, suggested that in choosing a chaplain, superintendents look for a "learning" rather than a learned man. A minster not so well oriented that he has lost humility might be more likely to avoid these dangers.

A plea was made on the very practical plane to provide hospital chaplains with sufficient physical facilities to enable them to conduct a good program. The special Catholic Chapel in the grounds of Longview State Hospital, Cincinnati, was mentioned. This was erected through contributions from the community and patients of all faiths use it for prayer and meditation.

A secondary—and it was emphasized that this was a very secondary—contribution made by the hospital chaplain was in terms of his public relations ability. He had valuable contacts in the community; he was able to invite other ecclesiastics into the hospital for orientation and education; he could open its doors to church groups in the community; he could encourage theological students to spend their summers working therein; he was, in fact, in a unique position to bring the mental hospital and the community closer together.

(Among those who contributed to the above discussion were: Dr. Granville L. Jones, Mr. Joseph Greco, Rev. Tom Morris, Father Bladstock, Miss Theresa Muller, Drs. Ralph M. Chambers, L. V. Lopez, R. Ginzberg and Robert C. Hunt.)

PSYCHOANALYSIS IN MENTAL HOSPITALS

Discussion Leader: Dr. Bernard Bandler, Boston, Mass.

In opening the discussion, Dr. Bandler pointed out that the problem of the psychonanalyst in state hospitals has a different aspect in the geographically isolated hospital and in the urban hospital. Although psychoanalysts have been in state hospitals since 1913, no comprehensive survey has been made of what psychoanalysis is contributing to psychiatry in public hospitals. The question of how best the psychoanalyst can function in the state hospital must be answered in terms of interchange of experience in teaching, research, and patient care.

We must consider not only what the psychoanalyst can contribute to the hospital, but what the hospital can contribute to him. This two-way concept must be kept in mind.

The difficulties arising in integrating the psychoanalyst into the hospital

staff were indicated by various adverse criticisms and specific examples. The psychoanalyst, it was said, is not willing, or perhaps not able, to deal with problems on the community level. He sees therapy exclusively as a long-term individual activity, and thus does not grasp the concept of community education and the preventive aspects of such education. He is critical of organic therapies, is skeptical of successful therapy with psychotics and tends to avoid them.

Examples of constructive contributions by psychoanalysts were also cited, particularly in hospitals with psychoanalytically oriented staffs. In a number of instances, psychoanalysts are reportedly functioning to good effect in patient care, in providing lectures and seminars to residents and other members of the hospital staff, in supervision of clinical work and participation in staff conferences, and in research.

The problem is not whether psychoanalysts in state hospitals are a "good" or a "bad" thing, it was pointed out. Rather, it is how to increase the small number available for hospital positions, and how to encourage them to remain in the state hospitals instead of moving on into private practice.

Trend Toward Integration

The differences that set psychoanalysts and other psychiatrists apart are far outweighed by what they have in common—namely, the advancement of the theory and practice of psychiatry, and a concern for the patients. There appears to be a trend among psychoanalysts of more awareness of community problems, and a growing willingness to assume responsibility on the community level. There is also more therapeutic optimism about psychotics and a willingness to modify analytical techniques, as indicated.

Cleavages have occurred in the past partly because the psychoanalyst, by the very nature of his training, has been out of contact with the community and the public hospital; and state hospital personnel, by the very nature of their work, are not familiar with the potential range of the psychoanalyst's contribution. Greater integration is needed, and is already in evidence.

Among those who contributed to the discussion were: Drs. Marvin L. Adland, Anthony K. Busch, L. M. Frank, Lora Hirsh, Robert W. Hyde, Irving Kartus, Maurice E. Linden, and Lucy D. Ozarin.

FARM POLICIES

Disc'n Leader: Dr. Charles H. Jones, Sedro-Woolley, Washington.

This group session focussed attention on the problem of the questionable value, both therapeutically and economically, of many hospital farms as presently operated, and sought means of turning the farm land into a positive asset through changes and modifications in operational policies.

Most mental institutions originally acquired their farms as a means of keeping active patients busy during the years when the hospital function was primarily custodial. With the shifted emphasis from custody to cure, the question of whether or not farms can be efficiently operated in harmony with modern treatment methods has become increasingly important.

The therapeutic value of the farm program is doubtful in view of the fact that diminished farm population has resulted in a small proportion of farm-trained mental patients. Most patients are uninterested in farm work, which becomes a distasteful chore rather than a therapeutic activity. In addition, there is an increase in the number of physically handicapped older patients and a rapid turnover among the younger ones, with a consequent difficulty in finding enough patients for whom farm work is a possibility.

Since the hospital exists for treatment, the farms must be justified on the basis of therapeutic value. Mechanized equipment adds to the difficulty, as most patients capable of operating the machinery are able to handle jobs outside the hospitals. However, the farms appear to have a real place as proving grounds for convalescent patients and can also provide vocational training.

Although the system of cost accounting shows a profit for the farms, in fact they are generally costly to the hospital. The sub-grade produce too frequently brought in, the large amount of waste and spoilage, and the seasonal "feasts and famines" are expensive features. Such things, while they do not show on the records, constitute a financial liability.

In view of these circumstances, the hospitals are paying attention to improving their farm operations in order to achieve maximum value from the land which is part of the institution and must be cultivated. Better planning is in order; for example, a conference including supervisor, dietitian and steward to plan each year's farm program would be likely to result in less waste. The fact that farming can be a profitable business indicates that it is possible for institutional farms to be more efficient, and thorough research into present day agricultural methods is one way of improving operations.

In addition, it is agreed that one undesirable aspect of farm work as part of the treatment program is the difficult schedule, especially in tending cows and poultry. Research into modern methods demonstrates that this is not necessary, and that such operations can be carried on at hours which will not interfere with the best care of the patient.

Since institutions in most cases can not afford to relinquish their farms, such careful planning toward increasing their economic value and harmonizing them with the treatment program is vital.

(Among those who contributed to the above discussion were Drs. Harold S. Magee, Granville L. Jones, George W. Jackson, Mr. K. T. Hawkins, C. L. Harrington, Fred Wold, Dr. D. O. Lynch, Crawford N. Baganz, Mr. Robert Slayter, R. Bruce Dunlap, Dr. Robert S. Garber, Mr. Albert Meuli and Dr. Roy W. Goshorn.)

DR. RILEY H. GUTHRIE DIES

Mental Hospital Service notes with deep regret the death of Dr. Riley H. Guthrie. Dr. Guthrie was stricken with a heart attack on Saturday, October 23, after his return from Minneapolis, where he attended the Sixth Mental Hospital Institute.

Dr. Guthrie, who was Mental Hospital Advisor to the National Institute of Mental Health, served as an M.H.S. Regional Representative and also as a consultant to the APA-M.H.S. Architectural Study Project.

CONTRIBUTION OF PROFESSIONAL PERSONNEL OTHER THAN PSYCHIATRISTS

Discussion Leader: Dr. John J. Prusmack, Palo Alto, Calif.

Teamwork in psychiatric treatment is just as necessary as teamwork in the management of an institution or in the carrying through of a piece of research, Dr. Prusmack pointed out, in opening the discussion. Psychiatric care has become too complex to be handled adequately by one discipline. It calls for action by many trained persons, working together.

There is agreement that general practitioners, nurses, social workers, and psychologists have much to contribute to total psychiatric treatment. The question is, how can the special resources and skills of these disciplines best be used in the hospital setting?

General Practitioners

Wider use of the general practitioner may in part mitigate the shortage of psychiatrists. We should recognize his potentialities in certain areas of mental hospital work. According to reports, general practitioners (in active service and in retired status) are members of hospital staffs on a full or part-time basis and are serving as staff consultants. Their experience and background fit them for work in geriatrics, for case-finding of physical illness (especially TBC), and for watching the general physical well-being of personnel and patients.

Nurses

As the traditional assistant to the doctor, the nurse has only recently become interested in psychiatric problems and is often hesitant to undertake psychiatric—as opposed to purely physical—care of patients. One facet of this problem is that, in general, nurses with adequate psychiatric training are placed in administrative positions, instead of in direct contact with patients. Many questions are raised by this situation. Should psychiatric nurses be encouraged to work more closely with individual patients? Should their work as supervisors of aides and volunteers be undertaken by other personnel? Should they have further post-graduate training? In view of the shortage of nurses, it would appear to be impractical to go too far in extending the period of preparatory training. Inservice education and more intensive psychiatric orientation within the hospital seem to be indicated.

The nurse plays a major role in the admission orientation of patients. She participates in ward conferences, takes an active part in leadership in group therapy, and encourages patients to participate in social, recreational, and occupational activities. In addition she carries on her traditional role.

Social Workers

Members of this discipline were first formally employed in mental hospitals in 1906, and since then they have become increasingly useful in the mental hospital set-up. From the first, they were utilized in obtaining social histories of patients, in preparing patients for discharge, and in supervising after-care. They have gradually been used more directly in psychiatric treatment.

Specifically, the social worker assists the family in gaining a better attitude toward mental illness, and thus assists in removing the stigma felt by relatives about having a member of the family in a mental hospital; she promotes adjustment of the patient to hospital life, and also furthers his adjustment to his home, his work, and his community after discharge. She is equipped to foster the hospital's relationships with health and welfare agencies, and in general with the community.

Psychologists

The clinical psychologists are the most recent professional group to join the hospital team. There have been some differences of opinion as to whether the contribution of this discipline should include psychotherapy or be more limited. It seems self-evident that personnel in this group can be useful in ward administration, in advice and guidance in the selection and utilization of personnel, in resolution of group tensions within the hospital community, in keeping open the channels of communication that are needed for successful hospital administration, and in psychotherapy with individuals and groups under the supervision of psychiatrists.

A better understanding of what each discipline can contribute to total patient care will go far in relieving the confusions and uncertainties that surround attempts to integrate non-psychiatric disciplines with psychiatry in the mental hospital setting. The functions of these disciplines should perhaps be more clearly defined, and they should be understood by psychiatrists. A warning was sounded, however, about laying down hard and fast rules. The plea was made to study how each patient can best be handled and to utilize all members of the "team" according to the needs of the individual patient.

(Among those who contributed to the above discussion were: Miss Theresa Muller, Drs. Philip N. Brown, Anthony K. Busch, Ralph M. Chambers, J. O. Cromwell, O. A. Kilpatrick, Arpad Pauncz, Lucy D. Ozarin, and Hyman Tucker.)

PROPERTY CONTROL & SECURITY MEASURES

Discussion Leader: Mr. Carl E. Applegate, Sacramento, Calif.

Accounting and supply methods, Mr. Applegate said in keynoting the discussion, are a means to the end of providing those things necessary to give treatment: personnel, buildings, supplies and equipment. Another state-level administrative director said that a good accounting system should provide management with the information it needs to run the hospital smoothly. It can do this only if the superintendent makes his wants known to the accounting section.

The advantages and disadvantages of centralized property control were debated. The major disadvantages, it was said, were that a central system is time-consuming and costly; as a rule, each institution must have two people working on it full-time. On the other hand, hospitals which operated under central property control felt that the savings it effected were considerable. They noticed that wards and offices made better use of supplies and equipment and that the time required to make annual inventory was saved. The practice of sending all departments a monthly itemization of their operating costs was said to be very effective in making personnel economy-conscious.

The problem of "spillage"—unaccountable losses, particularly of food, through pilfering or wastefulness—received much discussion. Several administrators offered their "pet cures" for the problem. In one hospital, for instance, any item on the menu that was not well-received, as evidenced by the amount left on the plates, was reported to the dietitian, who then saw that it was not served again.

The discussion also touched on clothing and linen supply procedures, quota versus marking systems. Quota systems should be flexible, said a state hospital superintendent, according to changes in ward situations and in the linen supply. At his hospital the quota is revised every three months.

The hospital laundry, it was said, plays an important role, for better or for worse, in determining clothing and linen quotas. "What happens to linens in our laundry is more obscure than the causes of schizophrenia," a doctor quipped. It was suggested that hospital laundries should use the operating standards prescribed by the American Institute of Laundering.

(Among those who contributed to this discussion were Drs. Harold Pooler, C. N. Baganz, Samuel Wick, and L. P. Ristine, Mr. Edward Merten, Mr. R. H. Richards, and Mr. Ralph E. Young.)

RECREATION IN MENTAL HOSPITALS

Discussion Leader: Dr. Robert W. Hyde, Boston, Massachusetts.

Dr. Hyde opened consideration of recreation in mental hospitals by posing a number of questions, among them: the relationship of recreation to pleasure, to the relief of painful tension; the problem of voluntary versus compulsory recreation; the balance between work (occupation) and play (recreation); the value of group versus individual recreation; and the evidence for and against the therapeutic contributions of recreation.

The professional recreation leader is a comparative newcomer to the mental hospital staff, and this fact in some measure accounts for the various reactions—pro and con—in regard to recreational therapy and the work of the trained recreation leader.

One viewpoint was that there is danger of too much organization of recreation, and that if there is too much regimentation and compulsion, the activity defeats its own purpose. On the other hand, some organization is needed to obtain a high percentage of voluntary participation. It was agreed that spontaneous social contacts among patients are desirable, and that any activities that result in their having "fun together" are valuable.

A well-rounded recreational program should ideally include arts and crafts, dancing, dramatics, music, entertainment both for and by the patients, sports and games, and outings. A wide variety of activities should be available to provide for all types of persons. The fact that the patient is an individual, with his own preferences in recreation, should be kept in mind.

In considering recreation for schizophrenics, the point was made that the schizophrenic derives great comfort from mastering a craft or skill. Much more than is now being done can be done for schizophrenics through recreational activities, and this aspect of recreation should be explored.

Observation of the patient at play increases an understanding of his problems and offers clues to the dynamics of his personality. In this respect, and also in the furthering of interpersonal contacts and aiding to adjustment to hospital life, recreation makes a direct contribution to therapy. It is, however, by no means a substitute for therapy.

It was stressed that the occupational and recreational therapists are highly trained, and that they should be integral members of the hospital staff. Volunteers reportedly can make constructive contributions in recreational activities under the direction of professional persons.

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(Among those who contributed the above discussion were Drs. J. O. Cromwell, Frank M. Gaines, Thomas L. Gore, Robert C. Hunt, Francis J. O'Neill, Mr. James W. Sanddal, Mr. Ralph Tucker, and Dr. W. R. Van Den Bosch.)

Provincial Mental Hospital, Essondale, B. C.

Active patient participation is often the key to meaningful recreation. This annual Halloween masquerade gives pleasure and activity for weeks, while patients plan their costumes, arrange entertainment and help decorate the hall.

ARCHITECTURAL STUDY

In order to enable MENTAL HOSPITALS to cover the Sixth Mental Hospital Institute comprehensively, the Architectural Study Project has relinquished some of its space this month.

PROGRAMMING & PLANNING FOR A PSYCHIATRIC HOSPITAL BUILDING

Discussion Leader: Mr. Moreland G. Smith, A.I.A.

In this session the respective responsibilities of architect and psychiatrist in the formulation of plans for a successful building were distinguished and emphasized. The discussion pointed up many of the fundamental problems confronting all participants in designing facilities for psychiatric treatment.

Among these problems were the need for flexibility to meet constantly changing procedures and practices, the impossibility of formulating a uniform standard building for any type of facility, and the difficulties involved in working out building relationships which will afford patients the desired amounts of personal privacy and separation from undesirable contacts. At the same time provision must be made for administrative and staff efficiency.

In his opening remarks, Mr. Smith stated strongly the extent of the responsibility of the architect and the psychiatrist. The architect's responsibility is the planning of space relationships to make every constructive effort as successful as possible. He solves a problem which must first be adequately stated by the person who will use the space he plans. The doctor's responsibility is to make known the uses of the building. Materials and structures are much less vital than the efficient solution of the space relation problem.

One of the most pressing of the problems stated is the requirement for sufficient flexibility to allow for the variation in practice among psychiatrists, and for ever-changing needs to keep pace with changing therapeutic trends. Among the solutions which might be offered is the construction of less permanent buildings which can be abandoned as needs change. It is thought unwise to invest $20,000 a bed in a building which in a number of years will require extensive remodeling, when progress in industry or medicine has made it obsolete.

Multi-purpose rooms, provided their primary function is kept in mind during planning, afford another possible solution to the problem of flexibility. Use of beds which might be removed and stored during the day has been considered as a means of permitting day-time use of sleeping space. The Japanese system of providing removable pallets for sleeping has this advantage, plus that of creating an atmosphere of normality for the patients. It was emphasized, however, that the use of space should be conceived on the local community's philosophy of life, and that any such day-night use of rooms would have to be adapted to the way of life with which the patient is familiar.

There are numerous objections to a uniform solution, by which buildings for certain purposes would be constructed alike at all hospitals. Standards, to be successful, must be taken as a point of departure rather than a solution. The question of horizontal versus vertical buildings, for instance, is dependent among other things on the availability of space. While the horizontal building is preferable in achieving a non-institutional atmosphere and allowing for maximum personal contact, the distribution of supplies is facilitated in the vertical building. Such points make each building an individual problem, and stringent standards would inevitably prove disadvantageous.

In addition, regional and climatic conditions require variation. The local architect can not be expected to achieve the most satisfactory result if he is limited to an inflexible, pre-conceived design. Formulae for numbers of baths and radiators can be standardized, but final forms and space relationships remain an individual matter.

The difficulty of patient readjustment to normal life in an atmosphere which affords little personal privacy is another problem. Likewise, mingling of patients of varying classifications causes trouble. Psychotic children need to be kept away from psychotic adults, yet administration is simplified if the children's unit is part of the main mental hospital. In this connection, New York has designed 200-bed children's units, sub-divided into very small sections, which are detached geographically, but attached administratively to the State hospital.

The neglected members of the design team, it was agreed, are the nurses and attendants who work with the patient. Progress would be made if these people with their intimate knowledge of procedures could be consulted during planning.

All programming and planning must be conceived on a broad basis, with the doctor making known what he wants the building to do for him, and the architect initiated into the usage of space when the doctor knows what he needs. The relationships—doctor to patient and patient to himself—must be understood by all concerned before the first schematic drawing is prepared.

(Among those who contributed to the above discussion were Dr. M. A. Tarumianz, Mr. Carl E. Applegate, Drs. Robert C. Hunt, Harvey J. Tompkins, Addison M. Duval, Randall MacLean, Paul Lemkau, Magnus Peterson, and Mr. Lorimer Rich.)

The Gateways, Los Angeles

This non-profit, metropolitan psychiatric facility, sponsored by the Jewish Committee for Personal Service, was designed to serve as a "temporary sheltered boarding home for patients ready to return to the community from state hospitals and and psychiatric hospitalization, but who needed a base of operations from which to integrate themselves within the community." The program has been expanded, however, and now provides facilities for outpatients and for inpatients from the community who need residential care, but minimal nursing.

(Photographs by Jack Garber)

There are ten beds—two 4-bed wards and two single rooms—in the residence building shown above. Three of the ten beds are free, and there is a nominal charge for the others. Maximum inpatient stay is 60 days. Both men and women are admitted. The original admission policy has been expanded to include patients on a non-sectarian basis.

An interior view of one of the four-bed wards. The fold-away beds are concealed in the cabinets, thus enabling the wards to be used also for group therapy sessions or other activities. Modern furniture, pleasant coloring, delicate yet durable curtains and "ordinary" fixtures avoid entirely a restrictive atmosphere.

A section of the treatment clinic, in the non-residence building. When the beds have been put away it is used for a recreation area as shown in the picture. The director hopes to bring in an occupational therapist and other activity personnel in the near future.

Staffing Pattern

The Gateways has two buildings, the residence and the treatment clinic. The latter offers both inpatient and outpatient shock therapy. A part-time paid psychiatrist screens all applications and coordinates care of inpatients and outpatients. Seven volunteer psychiatrists visit Gateways, carrying group and individual therapy sessions as well as shock treatments. A registered nurse, a psychiatrist and five volunteers man the treatment and recovery beds in the shock treatment room.

▼ *The dining room and kitchen in the residence building—note the convenient serving hatch and the table laid as if in a home or a restaurant. Through the "glass wall" can be seen the second building—the treatment clinic—and between the two buildings an outdoor area where patients may sit and chat together.*

▲ *ABOVE: An interior view in the residence building, showing a single bedroom and nurses' station to right. At the end of the corridor is the sick bay. Across from the single room are the two four-bed wards.*

Total Program

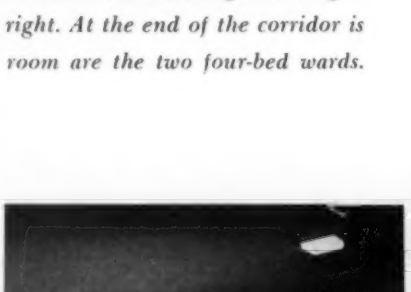
The ingenious use of limited space and funds enables Gateways to provide a needed community service. Five programs are offered: 1) Temporary residence, with board and care, for trial leave hospital patients; 2) Shock therapy for mild depressions, needing inpatient care, but minimum supervision; 3) Outpatient shock therapy; 4) Limited individual and group psychotherapy; 5) A social casework program.

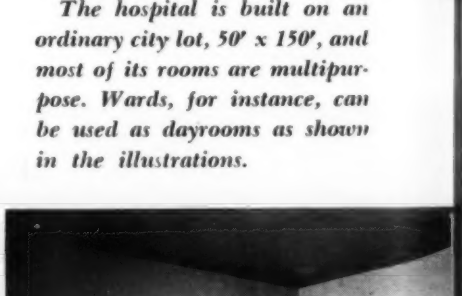
Since the Jewish Committee for Personal Service is a social work agency, the emphasis at Gateways is on rehabilitation rather than direct treatment. The casework staff of the Committee, all of whom have had psychiatric orientation, supply all the social service, employing welfare resources in the community to help patients to reestablish themselves.

The hospital is built on an ordinary city lot, 50' x 150', and most of its rooms are multipurpose. Wards, for instance, can be used as dayrooms as shown in the illustrations.

LEFT: The main room of the treatment clinic, in the treatment building, set up for shock therapy. This room, too, is multipurpose and can be used for activities when the shock therapy period is over.

RIGHT: Another interior view of the four-bed ward showing how the beds are folded away out of sight to enable the rooms to double for activity areas.





THE PSYCHIATRIST AS AN ADMINISTRATOR

By IRVING SHEFFEL, M.P.A. AND THOMAS DOLGOFF, M.S.E.
The Menninger Foundation, Topeka, Kansas

The American Psychiatric Association has officially recognized mental hospital administration as a specialty within psychiatry for which separate certification is now offered.* This forward step should encourage an increasing number of psychiatrists to select hospital administration as a career promising work satisfaction and professional prestige. In view of this development, we may anticipate considerable discussion about the relationship between psychiatry and administration.

The past twenty years have brought significant changes in the field of administration. A human relations point-of-view has replaced the earlier preoccupation with such efficiency devices as "time and motion study" and "work measurement." Formulation of management theory is no longer the exclusive province of the industrial engineer; indeed, even the application of that theory has become the joint concern of industrial engineers, psychologists, psychiatrists, anthropologists and other social scientists.

Administration Defined

Recently the Bureau of National Affairs addressed the following question to a representative group of 180 large and small firms: "If forced to choose a foreman between two individuals, one having outstanding job knowledge and the second having exceptional ability to handle people, which individual would you choose?" Ninety-eight percent of these firms stated they would choose the second individual. The reason given most frequently was that job knowledge can be taught more readily than skill in dealing with people. It is this concern with human problems in industry that has led many universities to devote substantial research effort to the study of actual problems involving interpersonal relationships in the work situation.

Most successful administrators today probably would agree that the primary function of the administrator is to influence the behavior of individuals so that they will work cooperatively in defining and accomplishing their group goals, at the same time providing maximum personal satisfaction to each member of the group. This definition emphasizes the role of the administrator in influencing behavior rather than attempting to dictate it, the importance of cooperative effort in establishing goals as well as working toward their achievement and the degree to which successful group effort depends upon the satisfactions each member derives from his participation in the group.

The group goals and personal satisfactions referred to in the above definition vary widely from one organization to another. Although there are many differences in the group and personal objectives of hospital staff and factory employees, both types of organizations have certain common characteristics. These may be grouped under two general categories of economic factors (production of products or services as efficiently as possible) and psychological factors (providing work satisfaction, social interaction and feelings of social acceptance and self-esteem).

The Psychiatrist

Assuming that he has a clear understanding of the hospital's goals and competence in solving professional medical problems, what attitudes and skills does the psychiatrist have which can be helpful to him in administration?

1. *Understanding of Motivation*—As a trained observer of human behavior, the psychiatrist has a keener awareness than others of why people act as they do. For example, he does not assume that cooperation can be secured by offering economic incentives alone, but realizes that there are varying types of satisfactions which different individuals seek in the work situation. Since administration depends so much upon motivating people so that they will contribute constructively to the group effort, the psychiatrist's understanding of motivation should prove valuable in all areas of administration.

2. *Skill in Listening*—One of the skills most essential to the administrator is the ability to perceive the difference between the literal content of a communication and its underlying meaning. Much of his time is

* *See elsewhere in MENTAL HOSPITALS for account of work of Committee on Certification of Mental Hospital Administrators.*

spent in receiving communications, and his decisions and actions are determined by what he hears or thinks he hears. Faulty interpretations of communications endanger the wisdom of his decisions. The administrator's day provides many illustrations of Voltaire's aphorism: "Men employ speech only to conceal their thoughts." He recognizes that such an apparently simple complaint as "This is a poor place to work!" may have any number of different meanings—inadequate supervision, low pay, difficult colleagues, insufficient recognition, unsatisfactory work facilities, etc. Since careful listening is a basic psychiatric skill, the psychiatrist enters administration with a potentially valuable tool.

3. *Patience*—Impatience in dealing with changes in human behavior is one of the most prevalent shortcomings of the inexperienced administrator. Expecting immediate compliance with any "reasonable" order he may issue, he may attribute "resistance" to his own inadequacies or the stubbornness of his staff, or both. He fails to realize that so simple a change as moving a desk may disrupt well-established interpersonal relationships that provide important social satisfactions to those concerned or that improving a filing system may involve learning a new set of habits. More extensive changes which may be interpreted as loss of status or power require even more complex personal adjustments, and resistance to such moves is the rule rather than the exception. The psychiatrist who has learned that an individual's behavior changes slowly in the treatment situation should be better prepared to accept the inevitable delays that occur as people adjust to new procedures and different methods.

4. *Flexibility*—The psychiatrist in his clinical practice does not base his judgments of people on conventional personality stereotypes but rather on the specific behavior of each individual. By adapting his own behavior to meet the needs of the patient he acquires a flexibility in dealing with a wide variety of personality types. The administrator needs similar attitudes and skills in dealing effectively with individuals of varying backgrounds who possess different value systems and whose personal goals may differ as widely as their technical jargon—the carpenter and the research scientist, the file clerk and the psychologist, the accountant and the social worker.

The Administrator

Although the psychiatrist enters administration with many potentially valuable tools he must learn to use these tools in an administrative rather than a therapeutic context. He must also acquire that additional body of knowledge and skills, which successful administration demands.

1. *Group Perspective*—In making a decision the administrator must be guided by a greater concern than the welfare of any single individual; what is good for one member of the group may be bad for the group as a whole. This soon becomes apparent to the new administrator when he deals with problems involving salaries, vacations, promotions, titles, official travel, etc. For example, it seems proper and reasonable to give special recognition through salary increase or promotion to a deserving employee, but the administrator should be prepared for negative reactions from others in the group. While they may not interpret this as unfair discrimination, they are being told at least indirectly that they are not valued as highly as their colleagues. A psychiatrist whose experience has been principally in a one-to-one relationship with individuals must learn to anticipate how his actions will influence the attitudes of the total group. This adds another dimension to the psychiatrist's frame of reference.

2. *Economics and Efficiency*—While the administrator should maintain high standards and lead his group toward ideal goals, he can ignore financial realities only at the risk of group self-destruction. Since there are never enough resources to satisfy the ambitions of an idealistic staff, the administrator must decide between the competing demands for each available dollar. He may plan his priorities systematically in accordance with an overall program or he may respond to each succeeding pressure until all the money is spent. If he hopes to use each dollar most effectively he must be familiar with the use of budgets, accounting reports, statistical analyses, salary scales and work schedules. Although he need not be an accountant or statistician, he must understand the language of these specialists sufficiently to be able to communicate with them and to guide them. He must understand the limitations as well as the values of budgetary and statistical procedures, for it is his responsibility to restrain the technicians from sacrificing human values in their zeal for technical perfection.

3. *Organization*—The training of a psychiatrist does not equip him to operate the machinery of organization. More likely than not, he conceives of organization policies and procedures as burdensome "red tape." The values of clear lines of authority, clarification of duties and responsibilities, and establishment of communication systems may not be readily apparent to the new administrator, but respect for them increases as he learns how they can be used to strengthen group stability and increase operating efficiency. It is often tempting to bypass responsible officials and deal directly with the man on the job, but the administrator who does this habitually risks a breakdown in his supervisory structure. Although there are occasions when the skillful administrator can use the informal organization effectively, he should always be aware of the dangers involved in circumventing the established pattern of supervisory responsibility.

4. *Employee Evaluation*—The psychiatrist has been trained to look at a patient from the point of view of personality pathology, and he may be tempted to evaluate employees in similar terms. The administrator on the other hand is concerned primarily with how successfully the employee performs his job and gets along with his fellow workers. If the employer-employee relationship is permitted to slide into a therapist-patient situation the administrative job becomes hopelessly complicated.

The psychiatrist is fortunate in entering administration with a rich background in the behavioral sciences. Once he realizes that the essence of administrative skill is the ability to motivate other people and that there is a body of accumulated knowledge about administration from which he can learn the additional techniques he requires, he can look forward to a rewarding and socially useful career in hospital administration.